Exhibit 21

08/05/2014 09:21 FAX 715 838 3649 LH BEH HEALTH 001

MAYO CLINIC HEALTH SYSTEM

Medical Fax

Location:
Inpatient Behavioral Health
1221 Whipple Street
Eau Claire, WI 54703

To: Julie Date & Time: 8/4/14 (1500)

Company/Dept.: Taylor County Human Svcs Fax: 715-748-3342

No. of Pages (including cover sheet): Phone:

Delivery Instructions: ☒ Routine ☐ Urgent

Special Instructions: As requested for TPC hearing.

From: Inpatient Behavioral Health Fax: 715-838-3649

Cori, CSW Phone: 715-838-3274

IMPORTANT: THE FOLLOWING ITEMS MUST BE COMPLETED to comply with Wisconsin statute that requires tracking of disclosed patient information outside Mayo Clinic Health System. Forward this completed cover page to the HIM Department at your site.

Please Print

Patient Name: Tamara M. Loertscher

Date of Birth: LOERTSCHER, TAMARA M DOB: [redacted] Age: 29Y Gender: F Admit: 08/01/2014 Att: SMITHBERG, NATH Rm#:19ALT Pt Type: Emergency PIN: [redacted] CLINIC#: [redacted] Number: [redacted]

Purpose for Release

REPORTS SENT:

- ☐ Clinic Notes
- ☒ Consult
- ☐ Discharge Summary
- ☐ Discharge Instructions
- ☐ ER Report
- ☐ EKG/tracing
- ☐ Face Sheet
- ☒ H & P
- ☐ Immunizations
- ☐ Lab Report
- ☐ Medications
- ☐ Operative Report
- ☐ Orders
- ☐ PPOC
- ☐ Progress Notes
- ☐ Pathology Report
- ☐ Radiology Reports
- ☐ Rehab (OT/PT)
- ☐ Worker Illness/Injury Form
- ☐ Other (Specify):

Consultation-Hospital LOERTSCHER, TAMARA M - [redacted]

Final Report

Signature Line
Electronically Signed By: BANTZ, JENNIFER S MD
On: 08/05/2014 08:27 AM
Modified by and Electronically Signed by: BANTZ, JENNIFER S MD
On: 08/05/2014 08:27 AM

Completed Action List:
* Perform by BANTZ, JENNIFER S MD on 05 August 2014 5:46 CDT
* Transcribe by ABDON, KIMBERLEY M on 05 August 2014 6:19 CDT
* Sign by BANTZ, JENNIFER S MD on 05 August 2014 8:27 CDTRequested on 05 August 2014 6:48 CDT
* Modify by BANTZ, JENNIFER S MD on 05 August 2014 8:27 CDT
* VERIFY by BANTZ, JENNIFER S MD on 05 August 2014 8:27 CDT

Printed by: EVERSON, CORINNA
Printed on: 08/05/2014 8:55 CDT

Consultation-Hospital LOERTSCHER, TAMARA M - [redacted]

* Final Report *

Result type: Consultation-Hospital
Result date: 02 August 2014 0:00 CDT
Result status: Auth (Verified)
Result title: PSYC-CON
Performed by: DUELLMAN, JARRED M MSW on 02 August 2014 12:10 CDT
Verified by: DUELLMAN, JARRED M MSW on 03 August 2014 9:18 CDT
Encounter info: 3036559, EU EauCl HospBH, Inpatient, 08/01/2014 -
Contributor system: MHS_DOLBEY_NORAD_SYS

* Final Report *

HDC C01519 (Verified)

SOCIAL WORK INITIAL ASSESSMENT

PATIENT IDENTIFICATION
PATIENT NAME: Tamara Loertscher, the patient goes by Tammy.
DATE OF BIRTH AND AGE: October 3, 1984, the patient is 29 years old.
GENDER: Female.
RESIDENCE AND CURRENT LIVING SITUATION: The patient has been residing in Medford, Wisconsin, which is in Taylor County with her boyfriend, her boyfriend's niece and her three children, a friend and her child and an acquaintance of the family.
MARITAL STATUS: Single.
EMPLOYMENT STATUS: Unemployed.
TYPE OF ADMISSION: Voluntary admission Taylor County.
FUNDING SOURCE: No insurance.
GUARDIAN (if applicable): None.
COUNTY SOCIAL WORKER (if applicable): None.

TOTAL TIME FOR ASSESSMENT PROCESS: Thirty minutes.

SOURCES OF INFORMATION
EMR review and a patient interview lasting 25 minutes.

CHIEF COMPLAINT/REASON FOR ADMISSION
"I was at the end of my rope."

HISTORY OF COMPLAINT OR PRESENT ILLNESS
The patient comes in voluntarily from Taylor County due to an increase in depression with passive suicidal thoughts. Tammy reports that these symptoms have been progressively getting worse and she feels that a lot of it

Consultation-Hospital LOERTSCHER, TAMARA M - [redacted]

* Final Report *

is caused by where she is living. She reports that she does not get along with her boyfriend's niece. They have been staying there due to some financial difficulties. She feels that her boyfriend's niece has been too possessive and has been taking advantage of them. Tammy reports that she has struggled with negative intrusive thoughts for quite some time. She indicates that at times her thoughts are so intrusive that she actually bangs her head in order to alleviate the thoughts. She does feel that at times she can be paranoid and distrustful of people. Tammy reports that she has had previous overdoses in the past neither of these overdoses have led to a hospitalization. She does indicate that she has been on medications before, however, never found it helpful. Tammy denies having any irregular outpatient provider. She reports in the past she has seen doctors as needed. Tammy reports that she recently found out that she was pregnant. She indicates that her and her boyfriend were trying to get pregnant feeling that if she were to have a baby it would give her "a purpose for living." Tammy also indicates that she has been using methamphetamine and THC since her pregnancy. Tammy reports that her use was reported to Taylor County Human Services when she met with them yesterday. Tammy continues to question whether or not she wants to be in the hospital. She continues to feel that people are judging her and is hesitant to give information regarding her symptoms and her circumstances that led to this hospitalization. She in fact ended the interview with me early due to these concerns.

PAST PSYCHIATRIC DIAGNOSES
Depressive disorder, not otherwise specified.

HISTORY OF PSYCHIATRIC AND SUBSTANCE ABUSE TREATMENT
OUTPATIENT PSYCHIATRIC AND SUBSTANCE ABUSE TREATMENT HISTORY: The patient is not currently seeing any regular providers for mental health issues.

INPATIENT PSYCHIATRIC AND SUBSTANCE ABUSE TREATMENT HISTORY: The patient denies.

SUBSTANCE ABUSE HISTORY: Patient reports drinking and using methamphetamine and marijuana on a fairly regular basis, she does indicate that her use had declined since she found out she was pregnant, she does not feel that she needs any services and can remain substance free after the leaves the hospital.

PAST MEDICAL/SURGICAL HISTORY
Please see hospitalist's history and physical for this admission.

MEDICATION HISTORY
Zoloft and Xanax.

FAMILY HISTORY
Positive for depression.

SOCIAL HISTORY
DEVELOPMENTAL HISTORY: The patient reports that she was born and raised in the Medford area. She indicates that she is not very close to her mother and is closest to her grandparents who also live in Medford. She

Consultation-Hospital LOERTSCHER, TAMARA M - [redacted]

* Final Report *

reports that she was thinking about trying to stay with her grandparents, however did not want to burden them. She is unclear where she will be staying indicating that she does not want to go back to her boyfriend's niece's home.

HISTORY OF ABUSE OR TRAUMA: Patient reports that in the past, she has been taken advantage of when she is under the influence of drugs or alcohol. She did not want to go into specifics.

CURRENT PATIENT AND FAMILY/PSYCHOSOCIAL CONCERNS: The patient is concerned about her mood and intrusive thoughts

EDUCATIONAL HISTORY: High school graduate. The patient also took some technical courses.

EMPLOYMENT HISTORY: Not currently working.

MILITARY HISTORY: None.

LEGAL HISTORY: The patient denies.

COMMUNITY RESOURCE USE: Recent involvement with Taylor County Human Services.

FINANCIAL CONCERNS: Limited finances. The patient reports that she is not currently working.

CULTURAL/RELIGIOUS/SPIRITUAL HISTORY/CONCERNS: None.

ADVANCE DIRECTIVES STATUS
Not assessed at this time.

PATIENT'S STRENGTHS
The patient has a hard time identifying strengths at this time.

PATIENT'S DEFICITS OR CHALLENGES
Struggling financially. Limited natural supports so she feels comfortable to about her issues.

PATIENT'S GOALS FOR HOSPITALIZATION/IDENTIFIED EMOTIONAL NEEDS
The patient is unable to identify specific goals. She reports that the doctor is going to look at possible medications she can take that are safe during her pregnancy.

IMPRESSION/REPORT/PLAN
IMPRESSION: Tamara, who goes by Tammy is a 29-year-old Caucasian female who comes in voluntarily from Taylor County due to an increase in depression intrusive thoughts and passive suicidal ideation. Tammy reports that she went to Taylor County Human Services yesterday because she was at the "end of her rope." She reports

Consultation-Hospital LOERTSCHER, TAMARA M - [redacted]

* Final Report *

that she spoke to someone over there who arranged for her to come into the hospital voluntarily. Tammy reports that her mother brought her to the hospital. Tammy feels that her symptoms have been progressively getting worse to the point where she is banging her head in order to deal with her intrusive thoughts. She has also been using illicit drugs and alcohol for which she reports as self medicating. Tammy continues to report paranoid thoughts and is distrustful of staff at times. She questions whether or not she should be in the hospital. She in fact ended my interview with her early because of these concerns. Tammy denies current suicidal ideation, she denies hallucinations to me.

TREATMENT/DISCHARGE PLAN: Doctor will meet with the patient and assess medications as well as the need for continued hospitalization. Groups and other activities will be encouraged if she is appropriate. Social work will meet with Tammy on a regular basis to address any therapeutic needs she may have. We will need to contact Taylor County Human Services on Monday to determine if they are in fact aware of Tammy's recent drug use while pregnant. Tammy does indicate that she met with them and they were aware of her use prior to coming into the hospital.

Jarred M. Duellman, M.S.W. L.C.S.W./slj
D: 08/02/2014 12:10 PM T: 08/02/2014 02:50 PM

Signature Line
Electronically Signed By: DUELLMAN, JARRED M MSW
On: 08/03/2014 09:18 AM
Modified by and Electronically Signed by: DUELLMAN, JARRED M MSW
On: 08/03/2014 09:18 AM

Completed Action List:
* Perform by DUELLMAN, JARRED M MSW on 02 August 2014 12:10 CDT
* Transcribe by JACOBSON, STACEE LOU on 02 August 2014 14:50 CDT
* Sign by DUELLMAN, JARRED M MSW on 03 August 2014 9:18 CDTRequested on 02 August 2014 15:32 CDT
* Modify by DUELLMAN, JARRED M MSW on 03 August 2014 9:18 CDT
* VERIFY by DUELLMAN, JARRED M MSW on 03 August 2014 9:18 CDT

Printed by: EVERSON, CORINNA
Printed on: 08/05/2014 8:55 CDT

Progress Note-Nurse

LOERTSCHER, TAMARA M - [redacted]

* Final Report *

Result type: Progress Note-Nurse
Result date: 01 August 2014 20:49 CDT
Result status: Auth (Verified)
Result title: BH nurse liaison data
Performed by: ADAMSKI, TRACEY RN on 01 August 2014 21:07 CDT
Verified by: ADAMSKI, TRACEY RN on 01 August 2014 23:48 CDT
Encounter info: 3036559, EU EauCl HospBH, Inpatient, 08/01/2014 -

* Final Report *

EMERGENCY DEPARTMENT BH ASSESSMENT

PATIENT INFORMATION
Collateral Information Provided By:

Referral Source:

Legal Status: voluntary

Activated POA or Guardian: Name & Phone of Legal Decision Maker:

County of Residence: Eau Claire

County SW or CSP:

Funding: no insurance

REASON FOR ED VISIT
Presenting Problems/symptoms: Pt. reports that she lost her insurance and went off her Synthroid for the past 3 months. She reports increased emotional instability, fighting with her boyfriend all the time, hearing voices and passive SI.

PATIENT HISTORY
Prior BH History hospitalization/treatment: Pt. denies.

Progress Note-Nurse

LOERTSCHER, TAMARA M - [redacted]

"Final Report"

Diagnosis: Depression, by hx.

Current Outpatient BH Providers: none

Primary MD: none

SUBSTANCE/CHEMICAL USE
Current substance use concerns: Pt. denies, however UDS was + for THC, Methamphetamine and amphetamines.

Hx of alcohol/substance use or abuse: Pt. reports using drugs and alcohol in the past.

Current AODA Outpatient Treatment: none

MENTAL STATUS:
GENERAL APPEARANCE: Dishevaled.
ALERTNESS/ORIENTATION: A&O x 3.
BEHAVIOR/MOTOR ACTIVITY: Pt. is restless and emotionally distraught.
MOOD: labile, crying
AFFECT: sad
THOUGHTS: both content and process: Racing. She reports having obsessive thoughts such as that if she eats a certain kind of candy, she is going to kill her baby. She reports that things try to get into my head - "really bad things and my head hurts." She feels like people are against her and that she can't trust anyone. She wants to run away from it all or have someone kill her, but knows that this would be taking the easy way out. She reports feeling a lot of anger and treating her boyfriend badly and scratching him all over. She admits to feeling very depressed and worthless and she feels like she gives relationships her all and she can't make them work.
SPEECH/LANGUAGE: overproductive, derails, tangential
MEMORY: seems to be intact
ATTENTION SPAN AND CONCENTRATION: Pt. has difficulty tracking to questions due to emotional lability. Pt. has trouble concentrating.
SUICIDAL/HOMICIDAL

Plan/Intent:
Pt. has thoughts to overdose on medications as she has in the past.

Progress Note-Nurse LOERTSCHER, TAMARA M - [redacted]

* Final Report *

Access to Means:

Hx of Attempts:
Pt. reports overdosing on Xanax in the past, but she did not seek medical help.
Protective Factors:
Her mom is supportive.

OTHER PERTINENT INFORMATION
Pt. has scattered bruising to her right wrist from where she notes that her boyfriend grabbed her wrists to keep her from hurting herself. She reports that sometimes she will bang her head on the wall to get the "thoughts" out and "thrashes" around all night. She is pregnant and Pt. reports that she missed her period for the past 3 months and thus suspected that she was pregnant. She took two home pregnancy tests recently both of which were positive. Pt. was taking an OTC supplement for her thyroid instead of Synthroid due to losing her insurance. She was only taking half as much as was prescribed on the bottle. Pt. has a family hx of Depression. Her boyfriend thinks that she is Schizophrenic and depressed. Pt. was seen by Dr. Sengodan in the ED. Writer contacted the oncall SW to find out about the provider's duty to report the patient to Child Protective Services, because of her drug use while pregnant. Mary, SW from Women's Health was oncall and she was going to look into this further and f/u with the patient on the IPBH floor tomorrow.

PLAN
Disposition: Admit to IPBH
Available Support People:
Mor
Safety Planning: To be done on IPBH.

Referrals:
To be done on IPBH.

Signature Line
Electronically Signed By: ADAMSKI, TRACEY RN
On: 08/01/2014 11:48 PM
Modified by and Electronically Signed by: ADAMSKI, TRACEY RN
On: 08/01/2014 09:12 PM

Completed Action List:

Progress Note-Nurse

LOERTSCHER, TAMARA M - [redacted]

"Final Report"

* Perform by ADAMSKI, TRACEY RN on 01 August 2014 21:07 CDT
* Modify by ADAMSKI, TRACEY RN on 01 August 2014 21:12 CDT
* Sign by ADAMSKI, TRACEY RN on 01 August 2014 23:48 CDT Requested by ADAMSKI, TRACEY RN on 01 August 2014 23:48 CDT
* Modify by ADAMSKI, TRACEY RN on 01 August 2014 23:48 CDT
* VERIFY by ADAMSKI, TRACEY RN on 01 August 2014 23:48 CDT

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Printed on: 08/06/2014 8:58 CDT

Progress Note-Nurse LOERTSCHER, TAMARA M - [redacted]

* Final Report *

Result type: Progress Note-Nurse
Result date: 01 August 2014 22:15 CDT
Result status: Auth (Verified)
Result title: Admission Note
Performed by: FOLEY, LORI A RN on 01 August 2014 22:34 CDT
Verified by: FOLEY, LORI A RN on 01 August 2014 22:34 CDT
Encounter info: 3036559, EU EauCl HospBH, Inpatient, 08/01/2014 -

* Final Report *

Patient comes to this unit voluntarily for depression. Patient metal detected upon arrival to unit with no contraband found. Patient is 3 months pregnant. Patient reports that she has been off her thyroid medication for 5 months due to losing her health insurance. Her UA is positive for meth., amphetaminee, and THC. ED BH Liason spoke with SW/Mary (women's Health) regarding mandatory reporting, Mary is going to check into same and call unit tomorrow regarding same. Patient mood labile. She is intermittently tearful, alert and oriented X 3, affect is flat. Patient reports family history of depression and states "I've been depressed my whole life". Patient admits that she had a suicide attempt approximately 2 years ago after a breakup with a boyfriend. She states that she is not feeling suicidal on the unit and will be safe here. Patient has bruising on right wrist, she states that earlier she was throwing around and boyfriend grabbed her wrists to try and stop her, she denies any abuse. Patient brought to ED by her mother whom she states is supportive. Patient completed admission SSF with one critical score Patient states that she Patient completed all admission paperwork, was cooperative during same. Patient currently on no psychiatric medications. Patient was seen by hospitalist in ED prior to arrival at unit. Patient given tour of unit, states understanding of all admission paperwork and states she has no questions at this time. Will continue to monitor and assess.

Signature Line
Electronically Signed By: FOLEY, LORI A RN
On: 08/01/2014 10:34 PM

Completed Action List:
* Perform by FOLEY, LORI A RN on 01 August 2014 22:34 CDT
* Sign by FOLEY, LORI A RN on 01 August 2014 22:34 CDT
* VERIFY by FOLEY, LORI A RN on 01 August 2014 22:34 CDT

Printed by: EVERSON, CORINNA
Printed on: 08/05/2014 8:58 CDT

Progress Note-Nurse LOERTSCHER, TAMARA M - [redacted]

* Final Report *

Result type: Progress Note-Nurse
Result date: 02 August 2014 9:33 CDT
Result status: Auth (Verified)
Result title: shift assessment
Performed by: FRENETTE, ANGIE R RN on 02 August 2014 9:55 CDT
Verified by: FRENETTE, ANGIE R RN on 02 August 2014 9:55 CDT
Encounter info: 3036559, EU EauCl HospBH, Inpatient, 08/01/2014 -

* Final Report *

Tamara (Tammy) was admitted to the unit with the target symptoms of mood lability, depression, and hallucinations. She presents with a sad mood, flat affect during 1:1. Tamara states that she has been feeling depressed for "a couple of years" and that recently she has felt as if she is unable to please anyone in her life. She states that she is unhappy with her living arrangements, her and her boyfriend currently live with her boyfriend's nieces and kids. She states that she frequently feels as if "something is being shoved into my head and it puts all these negative thoughts in there. I have been banging my head a lot at home just to relieve the pressure but I think my neck has started to hurt from whatever is being used to put those thoughts into my head". This writer explained that we don't allow head banging on the unit. Tamara was able to contract for safety and state she will let staff know if she has the urge to bang her head. We discussed her pregnancy, she states this is her first pregnancy and she is feeling "nervous" about it. She has not seen an OBGYN yet. She reports feelings of fatigue and weakness and relates this to her pregnancy. This writer asked Tammy how often she has been using THC and meth and she stated "not too often, once or twice a day. I mainly use it to take away that pain in my neck from those thoughts I was telling you about". We discussed effects drugs can have on her baby and alternative coping mechanisms such as deep breathing, journaling and attending groups. We also discussed the reason she was put on Ferrous Sulfate in regards to her pregnancy. She was encouraged to attend some groups today and not to isolate all day. She also reports lower back pain, a Kpad was ordered for comfort measures. Awaiting a call from Womens Health SW regarding mandatory reporting. Will continue to monitor, assess and offer emotional support.

Signature Line
Electronically Signed By: FRENETTE, ANGIE R RN
On: 08/02/2014 09:55 AM

Completed Action List:
* Perform by FRENETTE, ANGIE R RN on 02 August 2014 9:55 CDT
* Sign by FRENETTE, ANGIE R RN on 02 August 2014 9:55 CDT
* VERIFY by FRENETTE, ANGIE R RN on 02 August 2014 9:55 CDT

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Printed on: 08/06/2014 8:58 CDT

Progress Note-Nurse LOERTSCHER, TAMARA M - [redacted]

* Final Report *

Result type: Progress Note-Nurse
Result date: 02 August 2014 18:49 CDT
Result status: Auth (Verified)
Result title: Shift Note
Performed by: FOLEY, LORI A RN on 02 August 2014 19:00 CDT
Verified by: FOLEY, LORI A RN on 02 August 2014 19:00 CDT
Encounter info: 30368559, EU EauCl HospBH, Inpatient, 08/01/2014 -

* Final Report *

Tammy has been isolating to her room this shift. Patient came to this unit with target symptom of depression. Patient denies SI, SH or anxiety. Patient affect if flat, her eye contact satisfactory. Patient has has complaint of neck pain at back of head. Patient currently has a k-pad for her back and neck pain. This writer gave patient PRN tylenol and suggested patient try an ice pack. Patient later stated that neck pain had decreased from 7/10 to 1/10. Patient reports "feeling a knot on the left side of her neck". Patient stated to this writer that she would like to get a head CT during hospitalization as she "wonders if the thoughts I'm having (i.e. deja vu, bad thoughts) are medical in nature". Patient encouraged to speak with psychiatrist tomorrow regarding appropriateness of CT, this writer will also pass this information on in report. Patient signed medication consent form and received medication education for Trazodone and Prozac. Patient states having no questions regarding these medications. We continue to monitor and assess.

Signature Line
Electronically Signed By: FOLEY, LORI A RN
On: 08/02/2014 07:00 PM

Completed Action List:
* Perform by FOLEY, LORI A RN on 02 August 2014 19:00 CDT
* Sign by FOLEY, LORI A RN on 02 August 2014 19:00 CDT
* VERIFY by FOLEY, LORI A RN on 02 August 2014 19:00 CDT

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Printed on: 08/05/2014 8:58 CDT

COUNTY 142

Progress Note-Nurse LOERTSCHER, TAMARA M - [redacted]

* Final Report *

Result type: Progress Note-Nurse
Result date: 03 August 2014 12:30 CDT
Result status: Auth (Verified)
Result title: shift assessment
Performed by: FRENETTE, ANGIE R RN on 03 August 2014 12:43 CDT
Verified by: FRENETTE, ANGIE R RN on 03 August 2014 12:52 CDT
Encounter Info: 3038669, EU EauClaHospBH, Inpatient, 08/01/2014 -

* Final Report *

Tammy was admitted to the unit with the target symptoms of mood lability, depression and hallucinations. She presents with a stable mood, flat affect during 1:1. She states her depression increases and decreases depending on the time of day "nights are the worst for me". She also continues to make delusional statements regarding negative thoughts being "pushed into my head and this is why I have so much pressure in my neck". She was offered an ice pack and APAP for the pressure which she accepted and reported it was effective. She has been isolating to her room and did not attend any unit activities yesterday. This writer educated her on the different activities that happen on the unit and different skills that she may learn to utilize by attending some of these activities. She stated she would attend DBT groups today. She was initial dosed on Prozac this morning, education was completed regarding the medication and possible side effects. Will monitor for any side effects. Her BP continues to run slightly low but no critical. She was encouraged to drink fluids. Will continue to monitor, assess and offer emotional support.

Signature Line
Electronically Signed By: FRENETTE, ANGIE R RN
On: 08/03/2014 12:52 PM
Modified by and Electronically Signed by: FRENETTE, ANGIE R RN
On: 08/03/2014 12:52 PM

Completed Action List:
* Perform by FRENETTE, ANGIE R RN on 03 August 2014 12:43 CDT
* Sign by FRENETTE, ANGIE R RN on 03 August 2014 12:52 CDT Requested by FRENETTE, ANGIE R RN on 03 August 2014 12:52 CDT
* Modify by FRENETTE, ANGIE R RN on 03 August 2014 12:52 CDT
* VERIFY by FRENETTE, ANGIE R RN on 03 August 2014 12:52 CDT

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Printed on: 08/05/2014 8:58 CDT

Progress Note-Nurse LOERTSCHER, TAMARA M - [redacted]

* Final Report *

Result type: Progress Note-Nurse
Result date: 03 August 2014 19:34 CDT
Result status: Auth (Verified)
Result title: Shift Note
Performed by: FOLEY, LORI A RN on 03 August 2014 19:49 CDT
Verified by: FOLEY, LORI A RN on 03 August 2014 19:49 CDT
Encounter info: 3038559, EU EauCl HospBH, Inpatient, 08/01/2014 -

* Final Report *

Patient alert and oriented X 3, she has spent this shift in bed resting and reading. Patient displays flat affect with relatively good eye contact. Patient states that her depression continues "in waves". Patient continues to have neck pain which she rates 2/10. She states it feels "like there is a blockage and the blood flow isn't getting to my brain" Patient attended afternoon activity group. Patient stated that while she was playing bingo "I felt like I had done this before, but like I was somebody else". Patient states that every time she experiences deja vu that "I feel like I'm experiencing it as someone else". During 1:1 patient states that she was feeling better after "pulling the shade". Patient questioned regarding what she was meant, patient opened shade and pointed the a building across the court yard which had a piece of office equipment sitting visibly in the window. Patient pointed and states, I don't like that camera pointed at me. Patient received emotional/behavioral support this shift in reference to her paranoia and delusions. Will continue to assess and monitor and give support.

Signature Line
Electronically Signed By: FOLEY, LORI A RN
On: 08/03/2014 07:49 PM

Completed Action List:
* Perform by FOLEY, LORI A. RN on 03 August 2014 19:49 CDT
* Sign by FOLEY, LORI A RN on 03 August 2014 19:49 CDT
* VERIFY by FOLEY, LORI A RN on 03 August 2014 19:49 CDT

Printed by: EVERSON, CORINNA
Printed on: 08/05/2014 8:58 CDT

Progress Note-Nurse LOERTSCHER, TAMARA M - [redacted]

" Final Report "

Result type: Progress Note-Nurse
Result date: 04 August 2014 11:41 CDT
Result status: Modified
Result title: Nurse's Note
Performed by: KUHL, MITCHELL R RN on 04 August 2014 11:44 CDT
Verified by: KUHL, MITCHELL R RN on 04 August 2014 12:42 CDT
Encounter info: 3036559, EU EauCl HospBH, Inpatient, 08/01/2014 -

* Final Report *
Document Contains Addenda

Addendum by KUHL, MITCHELL R RN on 04 August 2014 13:08 CDT (Verified)
Day 4 SSF completed with zero critical values.

Signature Line
Modified by and Electronically Signed by: KUHL, MITCHELL R RN
On: 08/04/2014 01:08 PM

Patient presents with a pleasant affect this morning, and has been up reading in her bed as a distraction technique. She stated to this writer that she feels like she is ready to go home today, and she wrote out a list of goals for herself. Psychiatrist updated on patient's request and list. Patient denies any physical pain, and has been appropriate on the unit. Patient stated that she would attend groups today, but had no interest in attending exercise. I explained to her the importance of exercise and distress tolerance, however she still declined. Will monitor patient for safety, and will continue to provide emotional support.

Signature Line
Electronically Signed By: KUHL, MITCHELL R RN
On: 08/04/2014 12:42 PM
Modified by and Electronically Signed by: KUHL, MITCHELL R RN
On: 08/04/2014 12:42 PM

Completed Action List:
* Perform by KUHL, MITCHELL R RN on 04 August 2014 11:44 CDT
* Sign by KUHL, MITCHELL R RN on 04 August 2014 12:42 CDT Requested by KUHL, MITCHELL R RN on 04 August 2014 12:42 CDT
* Modify by KUHL, MITCHELL R RN on 04 August 2014 12:42 CDT
* VERIFY by KUHL, MITCHELL R RN on 04 August 2014 12:42 CDT
* Sign by KUHL, MITCHELL R RN on 04 August 2014 13:08 CDT
* Modify by KUHL, MITCHELL R RN on 04 August 2014 13:08 CDT

Printed by: EVERSON, CORINNA
Printed on: 08/05/2014 8:58 CDT

Progress Note-Nurse LOERTSCHER, TAMARA M - [redacted]

"Final Report"

Result type: Progress Note-Nurse
Result date: 04 August 2014 16:25 CDT
Result status: Auth (Verified)
Performed by: PHILLIPS, KARLENE MARIE RN on 04 August 2014 16:31 CDT
Verified by: PHILLIPS, KARLENE MARIE RN on 04 August 2014 16:31 CDT
Encounter info: 3036559, EU EauCl HospBH, Inpatient, 08/01/2014 -

* Final Report *

Met with patient at her request as she wanted to file a grievance, "I came in voluntarily, I want to leave and now I'm told can't". Patient was met with by social worker to discuss the Temporary Protective Custody order that her county had issued due to her use of street drugs in her pregnancy. I did explain to her that with the TPC the decision for discharge is taken out of our hands for now. She responded with "what about all the meds ya. want to give me here?" I did reassure her that the MD was aware of her pregnancy and would take that into consideration in ordering medication for her. Also that she could refuse those at this time. Tamara repeatedly asked about leaving and going to outpt care. I informed her that her county and our treatment team would work to have options that will protect both her and her baby, but for right now she would be staying in the hospital. Tamara minimizes her use, changes the subject or distracts to another complaint when this is identified as reason for TPC. I encouraged her to take this one day at a time, attend groups and focus on getting the tools to help her.

Signature Line
Electronically Signed By: PHILLIPS, KARLENE MARIE RN
On: 08/04/2014 04:31 PM

Completed Action List:
* Perform by PHILLIPS, KARLENE MARIE RN on 04 August 2014 16:31 CDT
* Sign by PHILLIPS, KARLENE MARIE RN on 04 August 2014 16:31 CDT
* VERIFY by PHILLIPS, KARLENE MARIE RN on 04 August 2014 16:31 CDT

Printed by: EVERSON, CORINNA
Printed on: 08/05/2014 8:38 CDT

Progress Note-Nurse

LOERTSCHER, TAMARA M - [redacted]

* Final Report *

Result type: Progress Note-Nurse
Result date: 04 August 2014 18:17 CDT
Result status: Auth (Verified)
Result title: Shift Assessment
Performed by: FRIENDFELLOWS, STEFANIE RN on 04 August 2014 18:25 CDT
Verified by: FRIENDFELLOWS, STEFANIE RN on 04 August 2014 19:29 CDT
Encounter Info: 3036559, EU EauCl HospBH, Inpatient, 08/01/2014 -

* Final Report *

Pt presents as flat and blunted. Does not make eye contact. Tamara contracts for safety on the unit. She has pedred to speak with this RN and said, "I'm not talking to anyone else until I talk to a lawyer". She has been withdrawn to her room during this shift. Pt denies physical concerns at this time. OB was contacted for a consult. Will continue to monitor and assess.

Signature Line
Electronically Signed By: FRIENDFELLOWS, STEFANIE RN
On: 08/04/2014 07:29 PM
Modified by and Electronically Signed by: FRIENDFELLOWS, STEFANIE RN
On: 08/04/2014 06:28 PM

Completed Action List:
* Perform by FRIENDFELLOWS, STEFANIE RN on 04 August 2014 18:25 CDT
* Modify by FRIENDFELLOWS, STEFANIE RN on 04 August 2014 18:28 CDT
* Sign by FRIENDFELLOWS, STEFANIE RN on 04 August 2014 19:29 CDT Requested by FRIENDFELLOWS, STEFANIE RN on 04 August 2014 19:29 CDT
* Modify by FRIENDFELLOWS, STEFANIE RN on 04 August 2014 19:29 CDT
* VERIFY by FRIENDFELLOWS, STEFANIE RN on 04 August 2014 19:29 CDT

Printed by: EVERSON, CORINNA
Printed on: 08/05/2014 8:58 CDT

Progress Note-Nurse LOERTSCHER, TAMARA M - [redacted]

" Final Report "

Result type: Progress Note-Nurse
Result date: 04 August 2014 22:08 CDT
Result status: Auth (Verified)
Result title: Data
Performed by: FRIENDFELLOWS, STEFANIE RN on 04 August 2014 22:09 CDT
Verified by: FRIENDFELLOWS, STEFANIE RN on 04 August 2014 22:13 CDT
Encounter info: 30036659 EU EauCl HospBH, Inpatient, 08/01/2014 -

* Final Report *

Pt was seen by OB this evening. Lab screens for gonorrhea,chlamydia and vaginitis pending. Tammy was brighter and spoke to this RN afterwards and said "I got a due date and the baby looks good. I feel so relieved. The baby is due January 29th". Pt smiled and made eye contact with this RN for the first time this shift. Will continue to monitor and assess.

Signature Line
Electronically Signed By: FRIENDFELLOWS, STEFANIE RN
On: 08/04/2014 10:13 PM
Modified by and Electronically Signed by: FRIENDFELLOWS, STEFANIE RN
On: 08/04/2014 10:13 PM

Completed Action List:
* Perform by FRIENDFELLOWS, STEFANIE RN on 04 August 2014 22:09 CDT
* Sign by FRIENDFELLOWS, STEFANIE RN on 04 August 2014 22:13 CDT Requested by: FRIENDFELLOWS, STEFANIE RN on 04 August 2014 22:13 CDT
* Modify by FRIENDFELLOWS, STEFANIE RN on 04 August 2014 22:13 CDT
* VERIFY by FRIENDFELLOWS, STEFANIE RN on 04 August 2014 22:13 CDT

Printed by: EMERSON, CORINNA
Printed on: 08/05/2014 8:58 CDT

H&P

LOERTSCHER, TAMARA M - [redacted]

* Final Report *

Result type: H&P
Result date: 01 August 2014 21:33 CDT
Result status: Auth (Verified)
Result title: IM ADM
Performed by: SENGODAN, MOHAN MD on 01 August 2014 20:58 CDT
Verified by: SENGODAN, MOHAN MD on 03 August 2014 19:14 CDT
Encounter Info: 30366559, EU EauCl HospBH, Inpatient, 08/01/2014 -
Contributor system: MHS_DOLBEY_NONRAD_SYS

* Final Report *

HDC:02485 (Verified)

DATE OF EXAMINATION: 08/01/2014

This is an adult medical history and physical examination summary in the Behavioral Health Unit.

CHIEF COMPLAINT/REASON FOR VISIT
Severe depression, patient is 3 months pregnant.

HISTORY OF PRESENT ILLNESS
Ms. Loertscher is a 29-year-old Caucasian lady with a known history of depression, polysubstance abuse, and 3 months pregnant who was referred to the emergency from Medford social services because of severe depression. Patient has been living in Medford with her boyfriend of 7 months. Patient is going through severe depression lately and unfortunately she has been using marijuana and meth during this time even after she knows about the pregnancy. She stated she feels guilty and worthless and to make herself hopeful she was doing that. Unfortunately, patient did not get any prenatal care so far. Patient is not using any prenatal vitamin or iron tablets. Patient admitted to the behavioral health unit voluntarily for further evaluation and management.

Patient has a known history of hypothyroidism. Patient was diagnosed with that when she was in high school. Patient has not taken prescription levothyroxine however she was tried on and off over-the-counter thyroid pills. Patient never checked thyroid levels recently. Patient does have some constipation. Patient does notice some fatigue.

SYSTEMS REVIEW
Pertinent findings are discussed in the History of Present Illness. Patient denies any abdominal cramps or vaginal bleeding. Patient was not able to recollect exactly when her last menstrual period was. Patient has been living with her boyfriend of 7 months in Medford. All other systems are reviewed and are negative.

PAST MEDICAL/SURGICAL HISTORY
MEDICAL:

H&P LOERTSCHER, TAMARA M - [redacted]

Final Report

1. Depression.
2. Polysubstance abuse.
3. Untreated hypothyroidism.

SURGICAL: None.

ALLERGIES
Rash, hives, and itching from sulfa and clindamycin.

SOCIAL HISTORY
Patient is single, lives with her boyfriend of 7 months in Medford. Patient is a lifelong nonsmoker. Patient used to drink a lot last year but currently none per her report. Patient uses marijuana and methamphetamine regularly until now. Patient is unemployed and she used to work as a nursing assistant in the past and she has some nursing college.

FAMILY HISTORY
Patient does not know about her father. Mother is 54 years old and has high cholesterol and depression. No known family history of premature coronary artery disease. Stroke, cancer in grandparents.

MEDICATIONS
Over-the-counter thyroid one a day.

PHYSICAL EXAMINATION
VITAL SIGNS: Blood pressure 134/85 mmHg, pulse rate 74 beats per minute, temperature 36.1 degrees, saturation 97% on room air.
GENERAL: Twenty-nine-year-old Caucasian lady who appears to be emotional and crying. Appears depressed.
HEENT: Head is normocephalic and atraumatic. Conjunctiva appears moist without erythema. Pupils are equal and reactive to light and accommodation, without nystagmus. Pharynx is without erythema or exudates and tonsils are not enlarged. Mucous membranes are moist.
NECK: Supple with no bruits, masses, or tenderness. There is no lymphadenopathy. Trachea is midline. Thyroid is not enlarged.
CARDIOVASCULAR: Heart is regular rate, S1 and S2 audible without murmurs, rubs, or thrills.
RESPIRATORY: Lungs sound clear to auscultation. No crackles or wheezing. Equal air entry.
GASTROINTESTINAL: Abdomen nondistended, soft, and nontender to palpation. No rebound tenderness. No signs of organomegaly. Bowel sounds normal.
EXTREMITIES: No edema, cyanosis or clubbing. Peripheral pulses intact bilaterally.
SKIN: Skin is warm and dry without evidence of suspicious lesions or bruising. No rash.
MUSCULOSKELETAL: No obvious loss of range of motion of upper and lower extremities. Strength is equal bilaterally.
NEUROLOGICAL: Speech is appropriate. Patient is alert and oriented to person, place, time, and situation. No gross focal neurological deficit noted.

H&P

LOERTSCHER, TAMARA M - [redacted]

"Final Report"

LABORATORY
Hemoglobin 9.8, hematocrit 29.1, white count 8.2, platelets 207, sodium 135, potassium 3.6, chloride 99, bicarb 28, BUN 13, creatinine 0.93, AST 62, ALT 68, bilirubin 0.7. Salicylate and acetaminophen levels are negative. Urine tox screen is positive for cannabinol, methamphetamine, and amphetamine. TSH is more than 100. Beta hCG is 94,130.

IMPRESSION/REPORT/PLAN
1. Depression and anxiety. Patient admitted to the behavioral health unit voluntarily. Further evaluation and management as per the psychiatric team.
2. Pregnant state. Patient is 3 months pregnant. She was unable to recall her last menstrual period, she thinks it might be the middle of May. Patient denied any abdominal cramping or vaginal bleeding. Patient has some yellowish discharge which could be physiological. I spoke with the on-call OB/Gyn, Dr. Ezenagu. Patient will get a pelvic ultrasound to confirm the pregnancy and date of conception. Since patient has anemia with a hemoglobin of 9.8, patient likely has some iron deficiency so we will start her on ferrous sulfate twice a day. Patient will also be started on prenatal vitamin. Given the constipation and since we are starting on the ferrous sulfate, I will start her on Colace 100 mg twice daily and senna S for constipation. Once we make sure the OB ultrasound is stable, then there is no need for the OB/Gyn to see her here in the hospital since normally the first visit would be with the OB/Gyn counselor in the clinic which should be arranged.
3. Hypothyroidism which is untreated. I will check a free T4. Patient will be started on levothyroxine 1.6 mg/kg which comes to around 125 mcg daily which will be started now. Patient stated she is not able to afford medications and that is why she did not do it. Patient needs assistance with her medications. Needs to recheck her thyroid level in 4 weeks.
4. Patient has polysubstance abuse. Counseled extensively to quit doing that given the pregnant state and patient is willing to quit and she seems to be determined.

We will follow the patient in the behavioral health unit as needed. Please call with any questions.

Mohan Sengodan MD./mcb
D: 08/01/2014 08:66 PM T: 08/02/2014 08:33 AM

Signature Line
Electronically Signed By: SENGODAN, MOHAN MD
On: 08/03/2014 07:18 PM
Modified by and Electronically Signed by: SENGODAN, MOHAN MD
On: 08/03/2014 07:18 PM

Completed Action List:
1 Perform by SENGODAN, MOHAN MD on 01 August 2014 20:56 CDT

Printed by: EVERSON, CORINNA
Printed on: 08/05/2014 8:58 CDT

H&P

LOERTSCHER, TAMARA M - [redacted]

* Final Report *

* Transcribed by BRILL, MARY C on 02 August 2014 8:33 CDT
* Modify by SENGODAN, MOHAN MD on 03 August 2014 19:14 CDT
* Sign by SENGODAN, MOHAN MD on 03 August 2014 19:14 CDTRequested on 02 August 2014 9:10 CDT
* VERIFY by SENGODAN, MOHAN MD on 03 August 2014 19:14 CDT

Printed by: EVERSON, CORINNA
Printed on: 08/05/2014 8:58 CDT

Flowsheet Print Request

Patient: LOER[illegible]SCHEF, TAMARA M
MRN: [redacted]

Date Range: 07/28/2014 10:27 CDT - 08/05/2014 10:27 CDT

Printed by: EVE[illegible]SON, CORINNA
Printed on: 08/0[illegible]2014 12:23 CDT

Lab View	08/01/2014 17:50 CDT	08/01/2014 17:44 CDT	08/01/2014 17:40 CDT
CBC			
Hgb		L 9.8 g/dL	
Hct		L 29.1 %	
WBC		6.2 x10(9)/L	
RBC		L 3.07 x10(12)/L	
MCV		95 fL	
RBC Distribution Width		14.8 %	
RDW-SD		(c) <<NOT	
Platelet		207 x10(9)/L	
Differential Type		AUTO	
Neutro Absolute		3.92 x10(9)/L	
Lymph Absolute		1.86 x10(9)/L	
Mono Absolute		L 0.29 x10(9)/L	
Eos Absolute		0.10 x10(9)/L	
Baso Absolute		0.02 x10(9)/L	
Note:		When the a	
Electrolytes			
Sodium Lvl		135 mmol/L	
Potassium Lvl		3.6 mmol/L	
Chloride		99 mmol/L	
CO2		26 mmol/L	
AGAP		10 mmol/L	
Chemistry Panel			
Alk Phos		L 30 unit/L	
Glucose Fasting		^ 97 mg/dL	
Creatinine		0.92 mg/dL	
GFR (MDRD)		^ >60.0 mL/	
BUN		13 mg/dL	
Calcium Lvl		9.0 mg/dL	
Protein Total		6.9 g/dL	
Albumin Lvl		4.3 g/dL	
AST		H 62 unit/L	
ALT		H 68 unit/L	
Bili Total		0.7 mg/dL	
Drug Monitoring/Toxicology			
Salicylate Lvl		^ L <1.0 mg	
Acetaminophen Lvl		^ <15.0 mc	
Urine Chemistry			
Urine Tricyclic Antidepressants	^ NEG		
Urine Tetrahydrocannabinol	^ * UNCON		
Urine Propoxyphene	^ NEG		
Urine Phencyclidine	^ NEG		
Urine Oxycodone	^ NEG		
Urine Opiates	^ NEG		
Urine Methamphetamines	^ * UNCON		
Urine Methadone	^ NEG		
Urine Cocaine	^ NEG		

Flowsheet Print Request

Patient: LOERSCHER, TAMARA M
MRN: [redacted]

Date Range: 07/28/2014 10:27 CDT - 08/05/2014 10:27 CDT

Printed by: EVERSON, CORINNA
Printed on: 08/05/2014 12:23 CDT

Lab View	08/01/2014 17:50 CDT	08/01/2014 17:44 CDT	08/01/2014 17:40 CDT
U Benzodiazepine	^ NEG		
U Barbiturates	^ NEG		
U Amphetamine	^ * UNCON		
Medical	FOR MEDIC		
Thyroid Tests			
TSH		^ H >100.0	
T4 Free			L 0.1 ng/dL
Pregnancy:			
Beta hCG Qnt		^ 94,130.0	

H&P

LOERTSCHER, TAMARA M - [redacted]

* Final Report *

Result type: H&P
Result date: 01 August 2014 21:33 CDT
Result status: Auth (Verified)
Result title: IM-ADM
Performed by: SENGODAN, MOHAN MD on 01 August 2014 20:56 CDT
Verified by: SENGODAN, MOHAN MD on 03 August 2014 19:14 CDT
Encounter info: 3036559, EU EauCl HospBH, Inpatient, 08/01/2014 -
Contributor system: MHS_DOLBEY_NONRAD_SYS

* Final Report *

HDCC02485 (Verified)

DATE OF EXAMINATION: 08/01/2014

This is an adult medical history and physical examination summary in the Behavioral Health Unit.

CHIEF COMPLAINT/REASON FOR VISIT
Severe depression, patient is 3 months pregnant.

HISTORY OF PRESENT ILLNESS
Ms. Loertscher is a 29-year-old Caucasian lady with a known history of depression, polysubstance abuse, and 3 months pregnant who was referred to the emergency from Medford social services because of severe depression. Patient has been living in Medford with her boyfriend of 7 months. Patient is going through severe depression lately and unfortunately she has been using marijuana and meth during this time even after she knows about the pregnancy. She stated she feels guilty and worthless and to make herself hopeful she was doing that. Unfortunately, patient did not get any prenatal care so far. Patient is not using any prenatal vitamin or iron tablets. Patient admitted to the behavioral health unit voluntarily for further evaluation and management.

Patient has a known history of hypothyroidism. Patient was diagnosed with that when she was in high school. Patient has not taken prescription levothyroxine however she was tried on and off over-the-counter thyroid pills. Patient never checked thyroid levels recently. Patient does have some constipation. Patient does notice some fatigue.

SYSTEMS REVIEW
Pertinent findings are discussed in the History of Present Illness. Patient denies any abdominal cramps or vaginal bleeding. Patient was not able to recollect exactly when her last menstrual period was. Patient has been living with her boyfriend of 7 months in Medford. All other systems are reviewed and are negative.

PAST MEDICAL/SURGICAL HISTORY
MEDICAL:

H&P LOERTSCHER, TAMARA M - [redacted]

* Final Report *

1. Depression.
2. Polysubstance abuse.
3. Untreated hypothyroidism.

SURGICAL: None.

ALLERGIES
Rash, hives, and itching from sulfa and clindamycin.

SOCIAL HISTORY
Patient is single, lives with her boyfriend of 7 months in Medford. Patient is a lifelong nonsmoker. Patient used to drink a lot last year but currently none per her report. Patient uses marijuana and methamphetamine regularly until now. Patient is unemployed and she used to work as a nursing assistant in the past and she has some nursing college.

FAMILY HISTORY
Patient does not know about her father. Mother is 51 years old and has high cholesterol and depression. No known family history of premature coronary artery disease. Stroke, cancer in grandparents.

MEDICATIONS
Over-the-counter thyroid one a day.

PHYSICAL EXAMINATION
VITAL SIGNS: Blood pressure 134/65 mmHg, pulse rate 74 beats per minute, temperature 36.1 degrees, saturation 97% on room air.
GENERAL: Twenty-nine-year-old Caucasian lady who appears to be emotional and crying. Appears depressed.
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H&P

LOERTSCHER, TAMARA M - [redacted]

"Final Report"

LABORATORY
Hemoglobin 9.6, hematocrit 29.1, white count 6.2, platelets 207, sodium 135, potassium 3.6, chloride 99, bicarb 26, BUN 13, creatinine 0.53, AST 62, ALT 68, bilirubin 0.7. Salicylate and acetaminophen levels are negative. Urine tox screen is positive for cannabinol, methamphetamine, and amphetamine. TSH is more than 101. Beta hCG is 94,130.

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3. Hypothyroidism which is untreated. I will check a free T4. Patient will be started on levothyroxine 1.6 mcg/kg which comes to around 125 mcg daily which will be started now. Patient stated she is not able to afford medications and that is why she did not do it. Patient needs assistance with her medications. Needs to recheck her thyroid level in 4 weeks.
4. Patient has polysubstance abuse. Counseled extensively to quit doing that given the pregnant state and patient is willing to quit and she seems to be determined.

We will follow the patient in the behavioral health unit as needed. Please call with any questions.

Mohan Sengodan MD/mcb
D: 08/01/2014 08:56 PM T: 08/02/2014 08:33 AM

Signature Line
Electronically Signed By: SENGODAN, MOHAN MD
On: 08/03/2014 07:14 PM
Modified by and Electronically Signed by: SENGODAN, MOHAN MD
On: 08/03/2014 07:14 PM

Completed Action List:
1: Perform by SENGODAN, MOHAN MD on 01 August 2014 20:56 CDT

Printed by: EVERSON, CORINNA
Printed on: 08/04/2014 12:24 CDT